STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003284	A. BUILDING _____ B. WING _____	09/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT HEART CENTER OF INDIANA LLC	10580 N MERIDIAN ST INDIANAPOLIS, IN 46290

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State hospital complaint. Complaint Number IN00105911 Unsubstantiated; lack of sufficient evidence Survey Dates: 9-17-2012 Facility Number: 003284 Surveyor: Deborah Franco, RN Public Health Nurse Surveyor St. Vincent Heart Center of Indiana is in compliance with 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules. QA: claughlin 09/24/12	S 000		